## CUMMINGS MANOOKIAN

#### **BRIAN CUMMINGS**

Licensed to practice in TN, GA, FL, CA and HI

Brian Manookian

Licensed to practice in TN

December 30, 2016

#### VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Dr. Clark Archer, ER Physician TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Dr. Archer:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Dr. Archer and his failure to diagnose and treat Mr. Ruffino's February 2016 stroke in the ER at StoneCrest Medical Center, including when he presented to StoneCrest Medical Center well within three hours of the onset of his change in status due to the stroke. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino 06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino 1206 South Sixth Street Mayfield, KY 42066

EXHIBIT 1A

45 Music Square West Nashville, TN 37203 T 615.266.3333 F 615.266.0250

Pauahi Tower 1003 Bishop St. Suite 2710 Honolulu, HI 96813

T 808.444.4800

F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian 45 Music Square West Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,

Brian Manookian

RE: John Ruffino

# <u>LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE</u> <u>PURSUANT TO TENN. CODE ANN. § 29-26-121(a)</u>

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

SECTION A: THIS SECTION	MUST BE COMPLETED FO	R ALL AUTHORIZA	ATIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959		
Provider's Name:	Recipient's Name:		
Dr. Deka Efobi	Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address 305 West Main Street	Address 1: 200 StoneCrest Boulevard		
Lebanon, TN 37087-3545	Address 2:		
	City Smyrna	State TN	Zip 37167
This authorization will expire on t Date:	he following (fill in the Date or the Event: Filing of Lawsuit		

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

#### I understand that:

- 1. I may refuse to sign this authorization and it is strictly voluntary.
- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

#### SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

## **SECTION C: SIGNATURES**

Signature of Patient Plan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FO	OR RELEASE OF PROTECTED MED	ICAL/HEALTH INFO	RMATION		
SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS					
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251			
Provider's Name:	Provider's Name: Recipient's Name:				
Neurology Clinic & Associates	Dr. Clark Archer, ER Physician TriStar StoneCrest				
Provider's Address 305 West Main Street					
Lebanon, TN 37087-3545	Address 2:				
	City Smyrna	State TN	Zip37167		
This authorization will expire on the Date:	following (fill in the Date or the Exert: Filing of Lawsuit	vent but not both)			
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	1			
Description of Information to be Us	ed or Disclosed: All PHI in Medical	Record for All Date	S		
<ol> <li>If I do not sign this form, my unless stated otherwise.</li> <li>I may revoke this authorizati actions taken prior to receiver is no longer be protected by feeds.</li> <li>I understand that my attorner</li> </ol>	norization and it is strictly voluntary health care and the payment for my on at any time in writing, but if I do ng the revocation.  I not a health plan or health care proderal privacy regulations and may pay will receive copies of all records receive a copy of this form after I si	y health care will not , it will not have any vider, the released in otentially be redisclo eceived through this	effect on any formation may sed.		
SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT	<del></del>			
The purpose of the release of my red AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be fun Suite 241, Nashville, TN, 37205, wi	ERMIT YOU TO DISCUSS THESE NTATIVES OUT OF THE PRESE of this authorization by Recipient shanished to my counsel, Cummings M	E MATTERS WITH NCE OF MY ATTO all be copied by Reci lanookian, 102 Wood	RNEYS. All pient's office and lmont Boulevard,		
SECTION C: SIGNATURES		-			

Signature of Patient / Rlan Member / Guardian / Representative:	3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

	TROTECTED WILL		
SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: Social Security No: XXX-XX-7251		
Provider's Name:	Recipient's Name:		
Neurology Clinic & Associates	Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address P.O. Box 414	Address 1: 200 StoneCrest Boulevard		
Brentwood, TN 37024-0414	Address 2:		
	City Smyrna	State TN	Zip 37167
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	•
I understand that:		***************************************	

- 1. I may refuse to sign this authorization and it is strictly voluntary.
- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
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#### SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

### **SECTION C: SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: Social Security No: XXX-XX-7251		
Provider's Name:	Recipient's Name:		
Dr. Clark Archer TriStar StoneCrest	Dr. Clark Archer, ER Physicia TriStar StoneCrest	an	
Provider's Address 1: 200 StoneCrest Boulevard 200 StoneCrest Boulevard			
Smyrna, TN 37167	Address 2:		
	City Smyrna	State TN	Zip37167
This authorization will expire on the Date:	ne following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	•
Purpose of Disclosure: Compliar	nce with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be U	sed or Disclosed: All PHI in Medica	l Record for All Dates	

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Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Dr. Clark Archer	Dr. Clark Archer, ER Physician TriStar StoneCrest		
Provider's Address 2910 South Church Street	Address 1: 200 StoneCrest Boulevard		
Suite B	Address 2:		
Murfreesboro, TN 37127	City Smyrna	State TN	Zip 37167
This authorization will expire on the Date:	following (fill in the Date or the Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medical	Record for All Dates	

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#### SECTION C: SIGNATURES

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Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETE	D FOR ALL AUTHORIZA	ATIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: StoneCrest Medical Center	Recipient's Name: Dr. Clark Archer, ER TriStar StoneCrest	Physician	
Provider's Address 200 StoneCrest Bouelvard	Address 1: 200 StoneCrest Boulevard		
Smyrna, TN 37167	Address 2:		
	City Smyrna	State TN	Zip 37167
This authorization will expire on the Date:	ne following (fill in the Date Event: Filing of Lav		

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

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Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	ALL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		-
StoneCrest Medical Center c/o CT Corporation System	Dr. Clark Archer, ER Physici TriStar StoneCrest	an	
Provider's Address 800 South Gay Street, #2021	Address 1: 200 StoneCrest Boulevard		
Knoxville, TN 37929-9710	Address 2:		
	City Smyrna	State TN	Zip 37167
This authorization will expire on the	e following (fill in the Date or the E	event but not both)	

Date: Event: Filing of Lawsuit

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

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#### **SECTION C: SIGNATURES**

Signature of Patient / Plan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

## CUMMINGS MANOOKIAN

#### **BRIAN CUMMINGS**

Licensed to practice in TN, GA, FL, CA and HI

BRIAN MANOOKIAN

Licensed to practice in TN

December 30, 2016

#### VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Dr. Clark Archer 2910 South Church Street, Suite B. Murfreesboro, TN 37127

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Dr. Archer:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Dr. Archer and his failure to diagnose and treat Mr. Ruffino's February 2016 stroke in the ER at StoneCrest Medical Center, including when he presented to StoneCrest Medical Center well within three hours of the onset of his change in status due to the stroke. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino 06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino 1206 South Sixth Street Mayfield, KY 42066

45 Music Square West Nashville, TN 37203 T 615.266.3333 F 615.266.0250

Pauahi Tower 1003 Bishop St. Suite 2710 Honolulu, HI 96813 T 808.444.4800 F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian 45 Music Square West Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,

Brian Manookian

RE: John Ruffino

# <u>LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE</u> <u>PURSUANT TO TENN. CODE ANN. § 29-26-121(a)</u>

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

HIPAA AUTHORIZATION F	OR RELEASE OF PROTECTED ME	DICAL/HEALTH INFORM	IATION
SECTION A: THIS SECTION	MUST BE COMPLETED FOR	ALL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Dr. Deka Efobi	Dr. Clark Archer		
Provider's Address 305 West Main Street	Address 1: 2910 South Church Street		·
Lebanon, TN 37087-3545	Address 2:		
	City Murfreesboro	State TN	Zip37127
This authorization will expire on the Date:	e following (fill in the Date or the Event: Filing of Lawsuit	Event but not both)	
Purpose of Disclosure: Complian	ce with Tenn. Code Ann. § 29-26-	121	
Description of Information to be U	sed or Disclosed: All PHI in Medic	cal Record for All Dates	
	horization and it is strictly volunta	•	affected

- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
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#### SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

### **SECTION C: SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251
Provider's Name:	Recipient's Name:	
Neurology Clinic & Associates	Dr. Clark Archer	
Provider's Address 305 West Main Street	Address 1: 2910 South Church Street	
Lebanon, TN 37087-3545	Address 2:	
	City Murfreesboro	State TN Zip 3712
This authorization will expire on the Date:	following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	1
Description of Information to be Use	ed or Disclosed: All PHI in Medica	Record for All Dates
<ul> <li>actions taken prior to receiving</li> <li>4. If the requester or receiver is no longer be protected by fection</li> <li>5. I understand that my attorney</li> <li>6. I, through my attorney, will a</li> </ul>	not a health plan or health care pro- deral privacy regulations and may p will receive copies of all records receive a copy of this form after I si	vider, the released information may otentially be redisclosed. eceived through this authorization.
The purpose of the release of my rec AUTHORIZATION DOES NOT PE RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be furn Suite 241, Nashville, TN, 37205, with	cords is for review by the Recipient ERMIT YOU TO DISCUSS THESI NTATIVES OUT OF THE PRESE of this authorization by Recipient shanished to my counsel, Cummings M	E MATTERS WITH THE NCE OF MY ATTORNEYS. All all be copied by Recipient's office and lanookian, 102 Woodmont Boulevard
SECTION C: SIGNATURES		
I have read the above and authorize and Moreover, I acknowledge and hereby psychiatric, HIV testing, HIV results	y consent that the released informat	cal and health information as stated. ion may contain alcohol, drug,
Signature of Patient / Plan Member /	110	Date: 3-18-16
Print Name of Guardian / Representa	ative (if annlicable):	Relationship to Patient (if applicable):

	MUST BE COMPLETED FOR A	
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251
Provider's Name:	Recipient's Name:	
Neurology Clinic & Associates	Dr. Clark Archer	
Provider's Address P.O. Box 414	Address 1: 2910 South Church Street	
Brentwood, TN 37024-0414	Address 2:	
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SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT	
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SECTION C: SIGNATURES		
I have read the above and authorize Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV results	y consent that the released informat	cal and health information as stated. ion may contain alcohol, drug,
Signature of Patient / Rlan Member		Date: 3-18-16
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HIPAA AUTHORIZATION FO	OR RELEASE OF PROTECTED MED	OICAL/HEALTH INFORM	IATION
SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		***
Dr. Clark Archer TriStar StoneCrest	Dr. Clark Archer		
Provider's Address 200 StoneCrest Boulevard	Address 1: 2910 South Church Street		
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	City Murfreesboro	State TN	Zip37127
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Description of Information to be Us	sed or Disclosed: All PHI in Medica	l Record for All Dates	
<ol><li>If I do not sign this form, m unless stated otherwise.</li></ol>		y health care will not be	ect on any

- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

#### SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

#### **SECTION C: SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED	FOR ALL AUTHORI	ZATIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security XXX-XX-729	
Provider's Name:	Recipient's Name:		
Dr. Clark Archer	Dr. Clark Archer		
Provider's Address 2910 South Church Street	Address 1: 2910 South Church Str	eet	
Suite B	Address 2:		
Murfreesboro, TN 37127	City Murfreesboro	State TN	Zip37127
This authorization will expire on the Date:	he following (fill in the Date o Event: Filing of Laws		1)
Purpose of Disclosure: Compliar	nce with Tenn. Code Ann. § 29	9-26-121	
Description of Information to be U	sed or Disclosed: All PHI in N	Medical Record for All	Dates
<ol> <li>If I do not sign this form, in unless stated otherwise.</li> <li>I may revoke this authoriza actions taken prior to receive the requester or receiver no longer be protected by formula in the standard that my attorned.</li> <li>I, through my attorney, will</li> </ol>	ation at any time in writing, bu ving the revocation. is not a health plan or health c ederal privacy regulations and ey will receive copies of all re	t if I do, it will not have are provider, the releas may potentially be red cords received through	e any effect on any ed information may isclosed.
SECTION B: NOTICE TO PR	OVIDER AND RECIPIENT	<u> </u>	
The purpose of the release of my re AUTHORIZATION DOES NOT I RECIPIENT OR THEIR REPRES medical records obtained pursuant a Bates-Numbered copy shall be fu Suite 241, Nashville, TN, 37205, v	PERMIT YOU TO DISCUSS ENTATIVES OUT OF THE I to this authorization by Recipumished to my counsel, Cumm	THESE MATTERS WERESENCE OF MY A ient shall be copied by hings Manookian, 102 V	ITH THE FTORNEYS. All Recipient's office and Woodmont Boulevard,
SECTION C: SIGNATURES			
I have read the above and authorize Moreover, I acknowledge and here psychiatric, HIV testing, HIV results	by consent that the released in		
Polomanio, ili v testing, rii v resul	is, or Aids information.		

Print Name of Guardian / Representative (if applicable): Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
StoneCrest Medical Center	Dr. Clark Archer		
Provider's Address 200 StoneCrest Bouelvard	Address 1: 2910 South Church Street		
Smyrna, TN 37167	Address 2:		
	City Murfreesboro	State TN	Zip 37127
This authorization will expire on the Date:	ne following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	•
Purpose of Disclosure: Complian	ce with Tenn. Code Ann. § 29-26-1	21	
Description of Information to be U	sed or Disclosed: All PHI in Medica	I Record for All Dates	
	tion at any time in writing, but if I d	•	affected fect on any
<ul> <li>3. I may revoke this authorizat actions taken prior to receive</li> <li>4. If the requester or receiver in no longer be protected by fe</li> <li>5. I understand that my attorned</li> </ul>		o, it will not have any effortier, the released infortier in the redisclosed received through this aut	fect on any mation may
<ul> <li>3. I may revoke this authorizat actions taken prior to receive</li> <li>4. If the requester or receiver in no longer be protected by fe</li> <li>5. I understand that my attorned</li> </ul>	ving the revocation.  Is not a health plan or health care proceeded and privacy regulations and may play will receive copies of all records receive a copy of this form after I s	o, it will not have any effortier, the released infortier in the redisclosed received through this aut	fect on any mation may
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SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIONS	
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
StoneCrest Medical Center c/o CT Corporation System	Dr. Clark Archer		
Provider's Address 800 South Gay Street, #2021	Address 1: 2910 South Church Street		
Knoxville, TN 37929-9710	Address 2:		
	City Murfreesboro	State TN	
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not-both)	
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	1	
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	
no longer be protected by fee 5. I understand that my attorne	ng the revocation.  not a health plan or health care proderal privacy regulations and may possible receive copies of all records receive a copy of this form after I si	otentially be redisclosed. eceived through this authori	
SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT		
The purpose of the release of my red AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, wi	ERMIT YOU TO DISCUSS THESINTATIVES OUT OF THE PRESE of this authorization by Recipient shanished to my counsel, Cummings Market to my counsel to m	E MATTERS WITH THE NCE OF MY ATTORNEY all be copied by Recipient's lanookian, 102 Woodmont	office and Boulevard,
SECTION C: SIGNATURES			
I have read the above and authorize	the disclosure of the protected medi y consent that the released informat		
psychiatric, HIV testing, HIV result	s, or AIDS information.	ion may contain arconol, ar	
psychiatric, HIV testing, HIV results Signature of Patient / Rlan Mensber Print Wame of Guardian / Represent	s, or AIDS information.  / Guardian / Representative:	Date: 3-18-1	



**BRIAN CUMMINGS** 

Licensed to practice in TN, GA, FL, CA and HI

**BRIAN MANOOKIAN** 

Licensed to practice in TN

December 30, 2016

#### VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Dr. Deka Efobi 305 West Main Street Lebanon, TN 37087-3545

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Dr. Efobi:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Dr. Efobi and her failure to diagnose and treat his signs and symptoms leading up to his February 2016 stroke to prevent that stroke from occurring as it did. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino 06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino 1206 South Sixth Street Mayfield, KY 42066

45 Music Square West Nashville, TN 37203 T 615.266.3333 F 615.266.0250

Pauahi Tower 1003 Bishop St. Suite 2710 Honolulu, HI 96813 T 808.444.4800 F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian 45 Music Square West Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Brian Manookian

# <u>LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE</u> <u>PURSUANT TO TENN. CODE ANN. § 29-26-121(a)</u>

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

	MOST BE COME BELLED FOR A	LL AUTHORIZAT	IONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Dr. Deka Efobi	Dr. Deka Efobi		
Provider's Address 305 West Main Street	Address 1: 305 West Main Street		
Lebanon, TN 37087-3545	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	e following (fill in the Date or the Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	1	
Description of Information to be Us	sed or Disclosed: All PHI in Medical	Record for All Dates	
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver is no longer be protected by fe</li> <li>5. I understand that my attorne</li> <li>6. I, through my attorney, will</li> </ul>	s not a health plan or health care proderal privacy regulations and may person will receive copies of all records receive a copy of this form after I significant.	vider, the released info tentially be rediscloseceived through this a	ormation may
0000000	OVIDER AND RECIPIENT		
SECTION B: NOTICE TO PRO			
The purpose of the release of my re AUTHORIZATION DOES NOT P RECIPIENT OR THEIR REPRESE medical records obtained pursuant t a Bates-Numbered copy shall be fur	cords is for review by the Recipient ERMIT YOU TO DISCUSS THESE ENTATIVES OUT OF THE PRESE of this authorization by Recipient shamished to my counsel, Cummings Mithin five days after the records are of the cords are of the cord	MATTERS WITH T NCE OF MY ATTOR III be copied by Recip anookian, 102 Wood	NEYS. All ient's office and mont Boulevard,
The purpose of the release of my re AUTHORIZATION DOES NOT P RECIPIENT OR THEIR REPRESE medical records obtained pursuant ta Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, w	cords is for review by the Recipient ERMIT YOU TO DISCUSS THESE ENTATIVES OUT OF THE PRESE to this authorization by Recipient shamished to my counsel, Cummings M	MATTERS WITH T NCE OF MY ATTOR III be copied by Recip anookian, 102 Wood	NEYS. All ient's office and mont Boulevard,
The purpose of the release of my re AUTHORIZATION DOES NOT P RECIPIENT OR THEIR REPRESE medical records obtained pursuant ta Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, w SECTION C: SIGNATURES  I have read the above and authorize Moreover, I acknowledge and hereby	cords is for review by the Recipient ERMIT YOU TO DISCUSS THESE ENTATIVES OUT OF THE PRESE to this authorization by Recipient shamished to my counsel, Cummings Mithin five days after the records are of the disclosure of the protected medically consent that the released informat	E MATTERS WITH T NCE OF MY ATTOR Ill be copied by Recip anookian, 102 Wood btained via this author cal and health inform	kNEYS. All ient's office and mont Boulevard, rization.
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01/15

SECTION A: THIS SECTION I	MUST BE COMPLETED FOR A	LL AUTHORIZATION	NS Z
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Neurology Clinic & Associates	Dr. Deka Efobi		
Provider's Address 305 West Main Street	Address 1: 305 West Main Street		-
Lebanon, TN 37087-3545	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Use	ed or Disclosed: All PHI in Medica	Record for All Dates	
<ul> <li>actions taken prior to receiving</li> <li>4. If the requester or receiver is no longer be protected by fection</li> <li>5. I understand that my attorned</li> </ul>	on at any time in writing, but if I do ng the revocation. not a health plan or health care pro deral privacy regulations and may p y will receive copies of all records r receive a copy of this form after I si	vider, the released inform otentially be redisclosed. eceived through this auth	nation may
SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT		
The purpose of the release of my red AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, wi	ERMIT YOU TO DISCUSS THESI NTATIVES OUT OF THE PRESE of this authorization by Recipient shanished to my counsel, Cummings M	E MATTERS WITH THI NCE OF MY ATTORNI all be copied by Recipien Ianookian, 102 Woodmo	EYS. All t's office and nt Boulevard,
SECTION C: SIGNATURES			
I have read the above and authorize Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV results	y consent that the released informat		
Signature of Patient / Plan Member	Guardian / Representative:	Date:	16

Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR	ALL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Neurology Clinic & Associates	Dr. Deka Efobi		
Provider's Address P.O. Box 414	Address 1: 305 West Main Street		
Brentwood, TN 37024-0414	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	e following (fill in the Date or the I Event: Filing of Lawsuit	Event but not both)	
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-1	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medic	al Record for All Dates	
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver is no longer be protected by fee</li> <li>5. I understand that my attorne</li> </ul>	on at any time in writing, but if I do ng the revocation. In not a health plan or health care pr deral privacy regulations and may by will receive copies of all records receive a copy of this form after I s	ovider, the released inform potentially be redisclosed received through this auth	nation may
SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT		
The purpose of the release of my rec AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, wi	ERMIT YOU TO DISCUSS THES NTATIVES OUT OF THE PRESIDENT AUTHORIZATION BY Recipient SHOULD THE PRESIDENT OF T	SE MATTERS WITH THE ENCE OF MY ATTORN To the copied by Recipier Manookian, 102 Woodmo	EYS. All nt's office and ont Boulevard,
SECTION C: SIGNATURES			
I have read the above and authorize	the disclosure of the protected med		
Moreover, I acknowledge and hereb	s, or AIDS information.	ition may contain alcohol	
Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV results Signature of Patient / Plan Member	s, or AIDS information.	Date: 3-18-	

HIPAA AUTHORIZATION F	OR RELEASE OF PROTECTED MEI	DICAL/HEALTH INFORM	IATION
SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	ALL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Dr. Clark Archer TriStar StoneCrest	Dr. Deka Efobi		
Provider's Address 200 StoneCrest Boulevard	Address 1: 305 West Main Street		
Smyrna, TN 37167	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	Event but not both)	
Purpose of Disclosure: Complian	ce with Tenn. Code Ann. § 29-26-1	21	
Description of Information to be Us	sed or Disclosed: All PHI in Medica	al Record for All Dates	
	horization and it is strictly voluntary y health care and the payment for m		affected

- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

#### SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

## **SECTION C: SIGNATURES**

Signature of Patient / Plan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR	ALL AUTHORIZATIO	ONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Dr. Clark Archer	Dr. Deka Efobi		
Provider's Address 2910 South Church Street	Address 1: 305 West Main Street		
Suite B	Address 2:		
Murfreesboro, TN 37127	City Lebanon	State TN	Zip 37087
This authorization will expire on th Date:	e following (fill in the Date or the Event: Filing of Lawsuit	Event but not both)	
Purpose of Disclosure: Complian	ce with Tenn. Code Ann. § 29-26-	21	
Description of Information to be Us	sed or Disclosed: All PHI in Medic	al Record for All Dates	
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver in no longer be protected by fe</li> <li>5. I understand that my attorned</li> </ul>	tion at any time in writing, but if I of ing the revocation.  I not a health plan or health care prederal privacy regulations and may by will receive copies of all records receive a copy of this form after I	ovider, the released info potentially be redisclose received through this au	rmation may d.
SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT		
The purpose of the release of my re AUTHORIZATION DOES NOT P RECIPIENT OR THEIR REPRESI medical records obtained pursuant a Bates-Numbered copy shall be fu Suite 241, Nashville, TN, 37205, w	ERMIT YOU TO DISCUSS THESENTATIVES OUT OF THE PRES to this authorization by Recipient simished to my counsel, Cummings	SE MATTERS WITH TI ENCE OF MY ATTORI hall be copied by Recipic Manookian, 102 Woodm	NEYS. All ent's office and nont Boulevard
SECTION C: SIGNATURES			
I have read the above and authorize Moreover, I acknowledge and here	by consent that the released inform		
psychiatric, HIV testing, HIV result	is, or AIDS information.		n, arug,
Signature of Patient / Rlan Member Print Name of Guardian / Represen	/ Guardian / Representative:	Date: 3-18-	-16

Date of Birth: 06-12-1959  Recipient's Name: Dr. Deka Efobi  Address 1: 305 West Main Street  Address 2: City Lebanon	Social Security No: XXX-XX-7251	
Dr. Deka Efobi  Address 1: 305 West Main Street  Address 2:		
Address 1: 305 West Main Street Address 2:		
305 West Main Street Address 2:	lou Th	
	C. TN	
City Lebanon	Cut TN	
	State TN	Zip 37087
following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
e with Tenn. Code Ann. § 29-26-12	21	
ed or Disclosed: All PHI in Medica	Record for All Dates	
ng the revocation.  not a health plan or health care proderal privacy regulations and may possible receive copies of all records records.	vider, the released inforontially be redisclosed eceived through this au	rmation may d.
OVIDER AND RECIPIENT		
ERMIT YOU TO DISCUSS THESI NTATIVES OUT OF THE PRESE of this authorization by Recipient shanished to my counsel, Cummings Market	E MATTERS WITH TH NCE OF MY ATTORN all be copied by Recipie Ianookian, 102 Woodm	NEYS. All ent's office and ont Boulevard,
Guardian / Representative:	Date: 3   8 -	-16
	e with Tenn. Code Ann. § 29-26-12 ed or Disclosed: All PHI in Medica corization and it is strictly voluntary health care and the payment for my on at any time in writing, but if I do ng the revocation.  not a health plan or health care probleral privacy regulations and may provide will receive copies of all records receive a copy of this form after I since the compact of the Recipient ERMIT YOU TO DISCUSS THESE OTTATIVES OUT OF THE PRESE of this authorization by Recipient shall shall be the disclosure of the protected medical process of the disclosure of the protected medical process of the protected process of the protected process of the protected pr	e with Tenn. Code Ann. § 29-26-121  ed or Disclosed: All PHI in Medical Record for All Dates  corization and it is strictly voluntary.  The health care and the payment for my health care will not be on at any time in writing, but if I do, it will not have any ed ing the revocation.  The notal health plan or health care provider, the released information privacy regulations and may potentially be redisclosed will receive copies of all records received through this audienceive a copy of this form after I sign it.  EVIDER AND RECIPIENT  The ords is for review by the Recipient listed above. THIS ERMIT YOU TO DISCUSS THESE MATTERS WITH THE NTATIVES OUT OF THE PRESENCE OF MY ATTORS of this authorization by Recipient shall be copied by Recipient shall be copied by Recipient shall be copied by Recipient this authorization by Recipient shall be copied by

HIPAA AUTHORIZATION FO	OR RELEASE OF PROTECTED MED	ICAL/HEALTH INFORM	ATION
SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
StoneCrest Medical Center c/o CT Corporation System	Dr. Deka Efobi		
Provider's Address 800 South Gay Street, #2021	Address 1: 305 West Main Street		
Knoxville, TN 37929-9710	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	
<ol><li>If I do not sign this form, my unless stated otherwise.</li></ol>	norization and it is strictly voluntary y health care and the payment for m	y health care will not be a	

- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

## SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

#### **SECTION C: SIGNATURES**

Signature of Patient Rian Member / Guardian / Representative: Date	3-18-16	
Print Name of Guardian / Representative (if applicable):  Relate	tionship to Patient (if applicable	e):

## CUMMINGS MANOOKIAN

**BRIAN CUMMINGS** 

Licensed to practice in TN, GA, FL, CA and HI

BRIAN MANOOKIAN

Licensed to practice in TN

December 30, 2016

#### VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Neurology Clinic & Associates P.O. Box 414 Brentwood, TN 37024-0414

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Neurology Clinic & Associates:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Neurology Clinic & Associates and its failure to diagnose and treat his signs and symptoms leading up to his February 2016 stroke to prevent that stroke from occurring as it did. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino 06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino 1206 South Sixth Street Mayfield, KY 42066

45 Music Square West Nashville, TN 37203 T 615.266.3333 F 615.266.0250

Pauahi Tower 1003 Bishop St. Suite 2710 Honolulu, HI 96813 T 808.444.4800 F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian 45 Music Square West Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely

Brian Manookian

# <u>LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE</u> <u>PURSUANT TO TENN. CODE ANN. § 29-26-121(a)</u>

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

HIPAA AUTHORIZATION F	OR RELEASE OF PROTECTEL	MEDICAL/HEALTH INF	ORMATION
SECTION A: THIS SECTION	MUST BE COMPLETED F	OR ALL AUTHORIZA	TIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security N XXX-XX-7251	0:
Provider's Name:	Recipient's Name:		
Dr. Deka Efobi	Neurology Clinic & Associates		
Provider's Address 305 West Main Street	Address 1: P.O. Box 414		
Lebanon, TN 37087-3545	Address 2:		
	City Brentwood	State TN	Zip 37024
This authorization will expire on the Date:	ne following (fill in the Date or Event: Filing of Laws	•	
Purpose of Disclosure: Complian	ce with Tenn. Code Ann. § 29	-26-121	
Description of Information to be U	sed or Disclosed: All PHI in N	1edical Record for All Da	tes
I understand that:  1. I may refuse to sign this aut 2. If I do not sign this form, m			ot he affected

- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

#### SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

#### SECTION C: SIGNATURES

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIONS		
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251		
Provider's Name:	Recipient's Name:			
Neurology Clinic & Associates	Neurology Clinic & Associates			
Provider's Address 305 West Main Street	Address 1: P.O. Box 414			
Lebanon, TN 37087-3545	Address 2:			
	City Brentwood	State TN 2	Zip 37024	
This authorization will expire on the following (fill in the Date or the Event but not both)  Date: Event: Filing of Lawsuit				
Purpose of Disclosure: Compliance				
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates		
actions taken prior to receive  4. If the requester or receiver is no longer be protected by fee  5. I understand that my attorne	on at any time in writing, but if I do ng the revocation. not a health plan or health care pro deral privacy regulations and may p will receive copies of all records r receive a copy of this form after I si	vider, the released informat otentially be redisclosed. eceived through this authori	ion may	
SECTION B: NOTICE TO PROVIDER AND RECIPIENT				
The purpose of the release of my rec AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, wi	ERMIT YOU TO DISCUSS THESINTATIVES OUT OF THE PRESE this authorization by Recipient shanished to my counsel, Cummings M	E MATTERS WITH THE NCE OF MY ATTORNEY all be copied by Recipient's lanookian, 102 Woodmont I	office and Boulevard,	
SECTION C: SIGNATURES				
I have read the above and authorize Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV results	y consent that the released informat			
Signature of Patient / Rlan Member	NO	Date: 3-18-1	6	
Print Name of Guardian / Represent	ative (if applicable):	Relationship to Patient (if a	applicable):	

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS				
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251		
Provider's Name:	Recipient's Name:			
Neurology Clinic & Associates	Neurology Clinic & Associates			
Provider's Address P.O. Box 414	Address 1: P.O. Box 414			
Brentwood, TN 37024-0414	Address 2:			
	City Brentwood	State TN Zip 3702		
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)		
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	1		
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates		
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver is no longer be protected by fee</li> <li>5. I understand that my attorne</li> </ul>	onot a health plan or health care proderal privacy regulations and may person y will receive copies of all records receive a copy of this form after I si	vider, the released information may otentially be redisclosed. eceived through this authorization.		
The purpose of the release of my rec AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to	cords is for review by the Recipient ERMIT YOU TO DISCUSS THESI NTATIVES OUT OF THE PRESE this authorization by Recipient shanished to my counsel, Cummings M	E MATTERS WITH THE NCE OF MY ATTORNEYS. All all be copied by Recipient's office and Ianookian, 102 Woodmont Boulevard		
SECTION C: SIGNATURES				
I have read the above and authorize Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV results	y consent that the released informat	cal and health information as stated. ion may contain alcohol, drug,		
Signature of Patient / Plan Member	NO	Date: 3-18-16		
Print Name of Guardian / Representation	ative (if applicable):	Relationship to Patient (if applicable):		

HIPAA AUTHORIZATION FO	OR RELEASE OF PROTECTED ME	DICAL/HEALTH INFORM	ATION
SECTION A: THIS SECTION	MUST BE COMPLETED FOR	ALL AUTHORIZATION	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Dr. Clark Archer TriStar StoneCrest	Neurology Clinic & Associat	es	
Provider's Address 200 StoneCrest Boulevard	Address 1: P.O. Box 414		
Smyrna, TN 37167	Address 2:		
	City Brentwood	State TN	Zip37024
This authorization will expire on the Date:	e following (fill in the Date or the I Event: Filing of Lawsuit	Event but not both)	
Purpose of Disclosure: Complian	ce with Tenn. Code Ann. § 29-26-1	21	
Description of Information to be Us	sed or Disclosed: All PHI in Medic	al Record for All Dates	
<ol><li>If I do not sign this form, m unless stated otherwise.</li></ol>	horization and it is strictly voluntar y health care and the payment for n ion at any time in writing, but if I d	ny health care will not be a	

- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

# **SECTION C: SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	<u> </u>
Provider's Name:	Recipient's Name:	J	
Dr. Clark Archer	Neurology Clinic & Associate	s	
Provider's Address 2910 South Church Street	Address 1: P.O. Box 414		
Suite B	Address 2:		
Murfreesboro, TN 37127	City Brentwood	State TN	Zip 37024
This authorization will expire on the Date:	e following (fill in the Date or the E- Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	!1	
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver is no longer be protected by fee</li> <li>5. I understand that my attorne</li> </ul>	ion at any time in writing, but if I do ing the revocation. Is not a health plan or health care pro deral privacy regulations and may property y will receive copies of all records receive a copy of this form after I si	vider, the released inforontially be redisclosed eceived through this au	rmation may d.
SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT		
The purpose of the release of my rec AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, wi	ERMIT YOU TO DISCUSS THESE INTATIVES OUT OF THE PRESE to this authorization by Recipient shamished to my counsel, Cummings March 1988.	E MATTERS WITH TH NCE OF MY ATTORN all be copied by Recipie Ianookian, 102 Woodm	NEYS. All ent's office and nont Boulevard,
SECTION C: SIGNATURES			
I have read the above and authorize Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV results	y consent that the released informat	cal and health informat	ion as stated. ol, drug,
Signature of Patient / Plan Member / Guardian / Representative: Date: 3-18-16			-16
Print Name of Guardian / Representa	ative (if applicable):	Relationship to Patien	II (if applicable):

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
StoneCrest Medical Center	Neurology Clinic & Associate	s	
Provider's Address 200 StoneCrest Bouelvard	Address 1: P.O. Box 414		
Smyrna, TN 37167	Address 2:		
	City Brentwood	State TN Zip 37024	
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	1	
Description of Information to be Us	sed or Disclosed: All PHI in Medica	Record for All Dates	
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver is no longer be protected by fe</li> <li>5. I understand that my attorne</li> </ul>	ion at any time in writing, but if I do ing the revocation. s not a health plan or health care pro deral privacy regulations and may p y will receive copies of all records r receive a copy of this form after I si	vider, the released information may otentially be redisclosed. eceived through this authorization.	
SECTION B: NOTICE TO PROVIDER AND RECIPIENT			
AUTHORIZATION DOES NOT P RECIPIENT OR THEIR REPRESE medical records obtained pursuant t	ENTATIVES OUT OF THE PRESE to this authorization by Recipient shamished to my counsel, Cummings M	E MATTERS WITH THE NCE OF MY ATTORNEYS. All all be copied by Recipient's office and lanookian, 102 Woodmont Boulevard,	
SECTION C: SIGNATURES	-		
I have read the above and authorize Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV result	y consent that the released informat	cal and health information as stated. ion may contain alcohol, drug,	
Signature of Patient / Rlan Member / Guardian / Representative:  Date: 3-18-16			
Print Name of Guardian / Represent	ative (if applicable):	Relationship to Patient (if applicable):	

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION			
SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATION	is
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
StoneCrest Medical Center c/o CT Corporation System  Neurology Clinic & Associates			
Provider's Address 800 South Gay Street, #2021	Address 1: P.O. Box 414 Address 2:		
Knoxville, TN 37929-9710			
	City Brentwood	State TN	Zip 37024
This authorization will expire on the following (fill in the Date or the Event but not both)  Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	
	norization and it is strictly voluntary y health care and the payment for m		ffected

- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

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### SECTION C: SIGNATURES

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

# CUMMINGS MANOOKIAN

**BRIAN CUMMINGS** 

Licensed to practice in TN, GA, FL, CA and HI

BRIAN MANOOKIAN
Licensed to practice in TN

December 30, 2016

# VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

StoneCrest Medical Center c/o CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear StoneCrest Medical Center:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of StoneCrest Medical Center and its failure to diagnose and treat Mr. Ruffino's February 2016 stroke in the ER at StoneCrest Medical Center, including when he presented to StoneCrest Medical Center well within three hours of the onset of his change in status due to the stroke. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino 06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino 1206 South Sixth Street Mayfield, KY 42066

45 Music Square West Nashville, TN 37203 T 615.266.3333 F 615.266.0250

Pauahi Tower 1003 Bishop St. Suite 2710 Honolulu, HI 96813 T 808.444.4800 F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian 45 Music Square West Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,

Brian Manookiar

RE: John Ruffino

# <u>LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE</u> <u>PURSUANT TO TENN. CODE ANN. § 29-26-121(a)</u>

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: Dr. Deka Efobi	Recipient's Name: StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 305 West Main Street	Address 1: 800 South Gay Street		
Lebanon, TN 37087-3545	Address 2: Suite 2021		
	City Knoxville	State TN	Zip37929
This authorization will expire on to Date:	he following (fill in the Date or the I Event: Filing of Lawsuit	Event but not both)	

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

### I understand that:

- 1. I may refuse to sign this authorization and it is strictly voluntary.
- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

# SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

# **SECTION C: SIGNATURES**

Signature of Patient / Rlan Mensber / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	Recipient's Name: StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 305 West Main Street Lebanon, TN 37087-3545	Address 1: 800 South Gay Street Address 2: Suite 2021		
	City Knoxville	State TN	Zip 37929
This authorization will expire on the following (fill in the Date or the Event but not both)  Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	

#### I understand that:

- 1. I may refuse to sign this authorization and it is strictly voluntary.
- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
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- 6. I, through my attorney, will receive a copy of this form after I sign it.

#### SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

# **SECTION C: SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	3-18-16
	Relationship to Patient (if applicable):

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Neurology Clinic & Associates	StoneCrest Medical Center c/o CT Corporation System		
Provider's Address P.O. Box 414	Address 1: 800 South Gay Street		
Brentwood, TN 37024-0414	Address 2: Suite 2021		
	City Knoxville	State TN	Zip 37929
This authorization will expire on the following (fill in the Date or the Event but not both)  Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121			

# I understand that:

- 1. I may refuse to sign this authorization and it is strictly voluntary.
- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

# SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

# **SECTION C: SIGNATURES**

C:-C ... (D) ... (

Signature of Patient / Rian Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: Social Security No: XXX-XX-7251		
Provider's Name:	Recipient's Name:		
Dr. Clark Archer TriStar StoneCrest	StoneCrest Medical Center c/o CT Corporation System		į
Provider's Address 200 StoneCrest Boulevard	Address 1: 800 South Gay Street		
Smyrna, TN 37167	Address 2: Suite 2021		
	City Knoxville	State TN	Zip 37929
This authorization will expire on th	e following (fill in the Date or the E	vent but not both)	

This authorization will expire on the following (fill in the Date or the Event but not both)

Date:

Event: Filing of Lawsuit

2.0.m / ming or Lawout

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

#### I understand that:

- 1. I may refuse to sign this authorization and it is strictly voluntary.
- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

## SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

### SECTION C: SIGNATURES

Signature of Patient / Rlan Member / Guardian / Representative:	3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	ALL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: Social Security No: XXX-XX-7251		
Provider's Name: Dr. Clark Archer	Recipient's Name: StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 2910 South Church Street	Address 1: 800 South Gay Street		
Suite B	Address 2: Suite 2021		
Murfreesboro, TN 37127	City Knoxville	State TN	Zip 37929
This authorization will expire on the Date:	ne following (fill in the Date or the E Event: Filing of Lawsuit	event but not both)	

2 to the fining of Edword

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

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# SECTION C: SIGNATURES

Signature of Patient / Plan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	N MUST BE COMPLETED FO	R ALL AUTHORIZAT	TIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No XXX-XX-7251	:
Provider's Name:	Recipient's Name:		
StoneCrest Medical Center	StoneCrest Medical Center c/o CT Corporation System	<del>-</del> -	
Provider's Address 200 StoneCrest Bouelvard	Address 1: 800 South Gay Street		
Smyrna, TN 37167	Address 2: Suite 2021		
	City Knoxville	State TN	Zip 37929
This authorization will expire on t Date:	he following (fill in the Date or th Event: Filing of Lawsuit		
Purpose of Disclosure: Complia	nce with Tenn. Code Ann. § 29-20	6-121	-
Description of Information to be U	Jsed or Disclosed: All PHI in Med	dical Record for All Date	es

#### I understand that:

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### SECTION C: SIGNATURES

Signature of Patient / Plan Member / Guardian / Representative:	3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	ALL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: StoneCrest Medical Center c/o CT Corporation System	Recipient's Name: StoneCrest Medical Center c/o CT Corporation System		
Provider's Address 1: 800 South Gay Street, #2021 800 South Gay Street			
Knoxville, TN 37929-9710	Address 2: Suite 2021		
	City Knoxville	State TN	Zip37929
This authorization will expire on th Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	Event but not both)	

Purpose of Disclosure: Compliance with Tenn. Code Ann. § 29-26-121

Description of Information to be Used or Disclosed: All PHI in Medical Record for All Dates

#### I understand that:

- 1. I may refuse to sign this authorization and it is strictly voluntary.
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# SECTION C: SIGNATURES

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

# CUMMINGS MANOOKIAN

**BRIAN CUMMINGS** 

Licensed to practice in TN, GA, FL, CA and HI

BRIAN MANOOKIAN
Licensed to practice in TN

December 30, 2016

# VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

StoneCrest Medical Center 200 StoneCrest Boulevard Smyrna, TN 37167

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear StoneCrest Medical Center:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of StoneCrest Medical Center and its failure to diagnose and treat Mr. Ruffino's February 2016 stroke in the ER at StoneCrest Medical Center, including when he presented to StoneCrest Medical Center well within three hours of the onset of his change in status due to the stroke. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino 06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino 1206 South Sixth Street Mayfield, KY 42066

45 Music Square West Nashville, TN 37203 T 615.266.3333 F 615.266.0250

Pauahi Tower 1003 Bishop St. Suite 2710 Honolulu, HI 96813 T 808.444.4800 F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian 45 Music Square West Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,

Brian Manbokian

RE: John Ruffino

# <u>LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE</u> <u>PURSUANT TO TENN. CODE ANN. § 29-26-121(a)</u>

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIONS	
Patient Name: JOHN RUFFINO	Date of Birth: Social Security No: XXX-XX-7251		
Provider's Name:	Recipient's Name:		
Dr. Deka Efobi	StoneCrest Medical Center		
Provider's Address 305 West Main Street	Address 1: 200 StoneCrest Boulevard		
Lebanon, TN 37087-3545	Address 2:		
	City Smyrna	State TN Zip:	37167
This authorization will expire on the Date:	ne following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Complian	nce with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be U	sed or Disclosed: All PHI in Medica	l Record for All Dates	
no longer be protected by forms.  5. I understand that my attorned.  6. I, through my attorney, will	is not a health plan or health care pro ederal privacy regulations and may p ey will receive copies of all records r I receive a copy of this form after I si	otentially be redisclosed. eceived through this authorizati	
SECTION B: NOTICE TO PR	OVIDER AND RECIPIENT		***************************************
AUTHORIZATION DOES NOT I RECIPIENT OR THEIR REPRES medical records obtained pursuant a Bates-Numbered copy shall be fu	ecords is for review by the Recipient PERMIT YOU TO DISCUSS THEST ENTATIVES OUT OF THE PRESE to this authorization by Recipient should be made to my counsel, Cummings Within five days after the records are contained.	E MATTERS WITH THE NCE OF MY ATTORNEYS. A all be copied by Recipient's offi Ianookian, 102 Woodmont Bou	ce and
SECTION C: SIGNATURES			
I have read the above and authorize Moreover, I acknowledge and here psychiatric, HIV testing, HIV resul	e the disclosure of the protected med by consent that the released informat ts, or AIDS information.	ical and health information as st ion may contain alcohol, drug,	ated.
Signature of Patient / Rlan Member	NO	Date: 3-18-16	
Print Name of Guardian / Represen	tative (if applicable):	Relationship to Patient (if applic	able):

SECTION A	A: THIS SECTION I	MUST BE COMPLETED F	OR ALL AUTHOR	IZATIONS
Patient Nam JOHN RUI		Date of Birth: Social Security No: XXX-XX-7251		
Provider's N	lame:	Recipient's Name:		
Neurology	Clinic & Associates	StoneCrest Medical Center		
Provider's A	Address Main Street	Address 1: 200 StoneCrest Boulev	ard	
_ebanon, ¯	TN 37087-3545	Address 2:		
		City Smyrna	State TN	Zip37167
This authoriz	zation will expire on the	following (fill in the Date of Event: Filing of Laws		th)
Purpose of D	Disclosure: Complianc	e with Tenn. Code Ann. § 29	)-26-121	
Description	of Information to be Us	ed or Disclosed: All PHI in M	nedical Record for Al	l Dates
understand	that:			
2. If I d		norization and it is strictly volve health care and the payment		ill not be affected
3. I may	y revoke this authorizati ns taken prior to receivi	on at any time in writing, but	if I do, it will not hav	ve any effect on any
4. If the	e requester or receiver is	not a health plan or health ca deral privacy regulations and	are provider, the relea	sed information may disclosed.
5. I und	lerstand that my attorne;	y will receive copies of all rec	cords received through	
		y will receive copies of all rec receive a copy of this form af		roug

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

### **SECTION C: SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251
Provider's Name: Neurology Clinic & Associates	Recipient's Name: StoneCrest Medical Center	
Provider's Address P.O. Box 414	Address 1: 200 StoneCrest Boulevard	
Brentwood, TN 37024-0414	Address 2:	All the second s
	City Smyrna	State TN Zip 3710
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not-both)
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	1
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver is no longer be protected by fee</li> <li>5. I understand that my attorne</li> </ul>	ion at any time in writing, but if I doing the revocation.  In not a health plan or health care proderal privacy regulations and may perform y will receive copies of all records receive a copy of this form after I si	vider, the released information may otentially be redisclosed. eceived through this authorization.
SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT	
The purpose of the release of my rec AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, wi	ERMIT YOU TO DISCUSS THESINTATIVES OUT OF THE PRESE of this authorization by Recipient should be to my counsel, Cummings Market to my counsel t	E MATTERS WITH THE NCE OF MY ATTORNEYS. All all be copied by Recipient's office a anookian, 102 Woodmont Bouleva
SECTION C: SIGNATURES		
I have read the above and authorize Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV results	y consent that the released informat	cal and health information as stated ion may contain alcohol, drug,
Signature of Patient / Plan Member	Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Represent	ative (ifamiliashla):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FOR RELEASE OF PROTECTED MEDICAL/HEALTH INFORMATION			
SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: Recipient's Name:			
Dr. Clark Archer TriStar StoneCrest	StoneCrest Medical Center		
Provider's Address 200 StoneCrest Boulevard	Address 1: 200 StoneCrest Boulevard		
Smyrna, TN 37167	Address 2:		
	City Smyrna	State TN	Zip 37167
This authorization will expire on the following (fill in the Date or the Event but not both)  Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	2.1	
Description of Information to be Us	sed or Disclosed: All PHI in Medical	Record for All Dates	
	horization and it is strictly voluntary y health care and the payment for m		ffected

- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

# SECTION C: SIGNATURES

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

	MUST BE COMPLETED F	OR ALL AUTHORIZA	TIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No XXX-XX-7251	0:
Provider's Name:	Recipient's Name:		
Dr. Clark Archer	StoneCrest Medical Cer	nter	
Provider's Address 2910 South Church Street	Address 1: 200 StoneCrest Bouleva	ard	, 1877
Suite B	Address 2:		
Murfreesboro, TN 37127	City Smyrna	State TN	Zip 37167
This authorization will expire on the Date:	ne following (fill in the Date or Event: Filing of Lawsu		1
Purpose of Disclosure: Complian	ce with Tenn. Code Ann. § 29-	-26-121	
Description of Information to be U	sed or Disclosed: All PHI in M	ledical Record for All Dat	tes
<ul> <li>3. I may revoke this authoriza actions taken prior to receive</li> <li>4. If the requester or receiver in no longer be protected by fe</li> <li>5. I understand that my attorne</li> <li>6. I, through my attorney, will</li> </ul>	ving the revocation.  is not a health plan or health ca  ederal privacy regulations and a  ey will receive copies of all rec	are provider, the released i may potentially be rediscludered through this	nformation may osed.
SECTION B: NOTICE TO PR	OVIDER AND RECIPIENT		· · · · · · · · · · · · · · · · · · ·
The purpose of the release of my re AUTHORIZATION DOES NOT F RECIPIENT OR THEIR REPRES medical records obtained pursuant a Bates-Numbered copy shall be fu Suite 241, Nashville, TN, 37205, w	PERMIT YOU TO DISCUSS TENTATIVES OUT OF THE Part to this authorization by Recipion in the property of the prop	THESE MATTERS WITH RESENCE OF MY ATTO ent shall be copied by Recings Manookian, 102 Woo	I THE ORNEYS. All sipient's office and odmont Boulevard,
SECTION C: SIGNATURES			1
SECTION C: SIGNATURES  I have read the above and authorize Moreover, I acknowledge and here psychiatric, HIV testing, HIV resul	by consent that the released inf		
I have read the above and authorize Moreover, I acknowledge and here	by consent that the released inf ts, or AIDS information.		

HIPAA AUTHORIZATION FO	OR RELEASE OF PROTECTED MED	ICAL/HEALTH INFORM	ATION
SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: StoneCrest Medical Center	Recipient's Name: StoneCrest Medical Center		
Provider's Address 200 StoneCrest Bouelvard	Address 1: 200 StoneCrest Boulevard		
Smyrna, TN 37167	Address 2:		
	City Smyrna	State TN	Zip 37167
This authorization will expire on the following (fill in the Date or the Event but not both)  Date: Event: Filing of Lawsuit			
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medical	Record for All Dates	
	norization and it is strictly voluntary y health care and the payment for m		ffected

- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
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# SECTION C: SIGNATURES

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

Date of Birth: 06-12-1959 Recipient's Name: StoneCrest Medical Center Address 1: 200 StoneCrest Boulevard Address 2: City Smyrna following (fill in the Date or the Event: Filing of Lawsuit	Social Security XXX-XX-725  State TN	
StoneCrest Medical Center  Address 1: 200 StoneCrest Boulevard  Address 2: City Smyrna  following (fill in the Date or the Event: Filing of Lawsuit		Zip37167
Address 1: 200 StoneCrest Boulevard Address 2: City Smyrna following (fill in the Date or the Event: Filing of Lawsuit		Zip37167
200 StoneCrest Boulevard Address 2: City Smyrna following (fill in the Date or the Event: Filing of Lawsuit		Zip37167
City Smyrna ollowing (fill in the Date or the Ev Event: Filing of Lawsuit		Zip37167
ollowing (fill in the Date or the Ev Event: Filing of Lawsuit		Zip 37167
Event: Filing of Lawsuit	ant hut not hoth	1
	ent out n <del>otao</del> th	)
with Tenn. Code Ann. § 29-26-12	1	
or Disclosed: All PHI in Medical	Record for All I	Dates
will receive copies of all records receive a copy of this form after I significant	vider, the release extentially be redi	ed information may sclosed.
rds is for review by the Recipient MIT YOU TO DISCUSS THESE TATIVES OUT OF THE PRESE! his authorization by Recipient shashed to my counsel, Cummings M	E MATTERS WI NCE OF MY AT Ill be copied by F anookian, 102 W	TH THE TTORNEYS. All Recipient's office and Voodmont Boulevard,
ill live days after the records are o	Otalied via tills a	audionization.
e disclosure of the protected mediconsent that the released information AIDS information.	cal and health in	formation as stated. alcohol, drug,
	Date:	
	ral privacy regulations and may powill receive copies of all records receive a copy of this form after I significant and RECIPIENT  rds is for review by the Recipient and Tyou to DISCUSS THESE TATIVES OUT OF THE PRESEIT his authorization by Recipient shapped to my counsel, Cummings Main five days after the records are of the disclosure of the protected medicionsent that the released information of the protected medicionsent that the released information in the consent that the released information is a consent that the released informa	ral privacy regulations and may potentially be redivill receive copies of all records received through the receive a copy of this form after I sign it.  TIDER AND RECIPIENT  Index is for review by the Recipient listed above. THE MIT YOU TO DISCUSS THESE MATTERS WITATIVES OUT OF THE PRESENCE OF MY ATTHES AUTHORIST AND RECIPIENT Shed to my counsel, Cummings Manookian, 102 Vising five days after the records are obtained via this are disclosure of the protected medical and health in consent that the released information may contain or AIDS information.

# CUMMINGS MANOOKIAN

**BRIAN CUMMINGS** 

Licensed to practice in TN, GA, FL, CA and HI

**BRIAN MANOOKIAN** 

Licensed to practice in TN

December 30, 2016

# VIA U.S. CERTIFIED MAIL – RETURN RECEIPT

Neurology Clinic & Associates 305 West Main Street Lebanon, TN 37087-3545

Re: Notice Required by Tenn. Code Ann. § 29-26-121(a)

Dear Neurology Clinic & Associates:

Brian Cummings and I represent John Ruffino and Martha Ruffino. We are their authorized agents. Through me and Mr. Cummings, Mr. Ruffino is asserting claims for healthcare liability against you. Martha Ruffino is Mr. Ruffino's wife, and she gives notice of her loss of consortium claim as that injury and damages were caused by the same health care negligence/malpractice referenced herein. I am hereby providing you notice under Tenn. Code Ann. § 29-26-121(a).

The claims arise out of care provided to John Ruffino by and on behalf of Neurology Clinic & Associates and its failure to diagnose and treat his signs and symptoms leading up to his February 2016 stroke to prevent that stroke from occurring as it did. Further, John Ruffino and Martha Ruffino seek all damages available in a health care liability action in Tennessee.

The full name and date of birth of the patient whose treatment is at issue is:

John Ruffino 06-12-1959

The name and address of the claimants authorizing notice are:

John & Martha Ruffino 1206 South Sixth Street Mayfield, KY 42066

45 Music Square West Nashville, TN 37203 T 615.266.3333 F 615.266.0250

Pauahi Tower 1003 Bishop St. Suite 2710 Honolulu, HI 96813 T 808.444.4800 F 808.444.4888

www.cmtriallawyers.com

The name and address of the attorney sending this notice is:

Brian Manookian 45 Music Square West Nashville, TN 37203

Enclosed is a list of the names and addresses of all providers being sent a notice at this time. Also enclosed are HIPAA-compliant medical authorizations which will permit you to obtain complete medical records from each other provider being sent a notice.

Tenn. Code Ann. § 29-26-121(a)(5) requires that a health care provider, who receives notice of a potential claim for health care liability, "shall, within thirty (30) days of receiving the notice, based upon any reasonable knowledge and information available, provide written notice to the potential claimant of any other person, entity, or health care provider who may be a properly named defendant."

Sincerely,

Brian Manookian

RE: John Ruffino

# <u>LIST OF NAMES AND ADDRESSES OF ALL PROVIDERS BEING SENT A NOTICE</u> <u>PURSUANT TO TENN. CODE ANN. § 29-26-121(a)</u>

Provider	TN Dept. of Health Website Address	Provider's Current Business Address	Address of Registered Agent
Dr. Deka Efobi	Brentwood, TN 37024-0414	305 West Main Street Lebanon, TN 37087-3545	N/A
Neurology Clinic & Associates	N/A	305 West Main Street Lebanon, TN 37087-3545	P.O. Box 414 Brentwood, TN 37024-0414
Dr. Clark Archer	Brentwood, TN 37027	TriStar StoneCrest 200 StoneCrest Boulevard Smyrna, TN 37167	N/A
Dr. Clark Archer	Brentwood, TN 37027	2910 South Church Street Suite B Murfreesboro, TN 37127	N/A
StoneCrest Medical Center	N/A	200 StoneCrest Boulevard Smyrna, TN 37167	CT Corporation System 800 South Gay Street, #2021 Knoxville, TN 37929-9710

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251
Provider's Name: Dr. Deka Efobi	Recipient's Name: Neurology Clinic & Associate	s
Provider's Address 305 West Main Street	Address 1: 305 West Main Street	
Lebanon, TN 37087-3545	Address 2: City Lebanon	State TN Zip 37087
This authorization will expire on the Date:	following (fill in the Date or the E Event: Filing of Lawsuit	vent but not-hoth)
Purpose of Disclosure: Compliance  Description of Information to be Us	e with Tenn. Code Ann. § 29-26-12	
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver is no longer be protected by fee</li> <li>5. I understand that my attorne</li> </ul>	s not a health plan or health care proderal privacy regulations and may p y will receive copies of all records receive a copy of this form after I si	vider, the released information may otentially be redisclosed. eceived through this authorization.
The purpose of the release of my red AUTHORIZATION DOES NOT PI RECIPIENT OR THEIR REPRESE medical records obtained pursuant to a Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, wi	ERMIT YOU TO DISCUSS THESINTATIVES OUT OF THE PRESE this authorization by Recipient shanished to my counsel, Cummings M	E MATTERS WITH THE NCE OF MY ATTORNEYS. All all be copied by Recipient's office and Ianookian, 102 Woodmont Boulevard,
SECTION C: SIGNATURES		
I have read the above and authorize Moreover, I acknowledge and hereb psychiatric, HIV testing, HIV result	y consent that the released informat	cal and health information as stated. ion may contain alcohol, drug,
Signature of Patient / Plan Member	NO	Date: 3-18-16
Print Name of Guardian / Represent	atīve (if applicable):	Relationship to Patient (if applicable):

	MUST BE COMPLETED FOR A	LL AUTHORIZATIO	ONS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
Neurology Clinic & Associates	Neurology Clinic & Associate	s	
Provider's Address 305 West Main Street	Address 1: 305 West Main Street		
Lebanon, TN 37087-3545	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	. I
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	
actions taken prior to receive		•	
<ul><li>5. I understand that my attorne</li><li>6. I, through my attorney, will</li></ul>	deral privacy regulations and may p y will receive copies of all records r receive a copy of this form after I si	otentially be redisclosed eceived through this au	rmation may d.
no longer be protected by fe 5. I understand that my attorne 6. I, through my attorney, will  SECTION B: NOTICE TO PRO	deral privacy regulations and may p y will receive copies of all records r receive a copy of this form after I si OVIDER AND RECIPIENT	otentially be redisclosed eceived through this au- gn it.	rmation may d.
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no longer be protected by fe 5. I understand that my attorne 6. I, through my attorney, will  SECTION B: NOTICE TO PRO  The purpose of the release of my rea  AUTHORIZATION DOES NOT P.  RECIPIENT OR THEIR REPRESE  medical records obtained pursuant ta  Bates-Numbered copy shall be fur	deral privacy regulations and may p y will receive copies of all records r receive a copy of this form after I si  OVIDER AND RECIPIENT  cords is for review by the Recipient ERMIT YOU TO DISCUSS THESE ENTATIVES OUT OF THE PRESE of this authorization by Recipient sha mished to my counsel, Cummings M	otentially be redisclosed eceived through this aut gn it.  listed above. THIS E MATTERS WITH THIS NCE OF MY ATTORN all be copied by Recipie fanookian, 102 Woodm	rmation may d. thorization. HE NEYS. All ent's office and
no longer be protected by fe 5. I understand that my attorne 6. I, through my attorney, will  SECTION B: NOTICE TO PRO  The purpose of the release of my rea  AUTHORIZATION DOES NOT P  RECIPIENT OR THEIR REPRESE  medical records obtained pursuant ta  Bates-Numbered copy shall be fur  Suite 241, Nashville, TN, 37205, will	deral privacy regulations and may p y will receive copies of all records r receive a copy of this form after I si  OVIDER AND RECIPIENT  cords is for review by the Recipient ERMIT YOU TO DISCUSS THESE ENTATIVES OUT OF THE PRESE to this authorization by Recipient sha mished to my counsel, Cummings M ithin five days after the records are of the disclosure of the protected medical to consent that the released information	otentially be redisclosed eceived through this aut gn it.  listed above. THIS E MATTERS WITH THORE OF MY ATTORN all be copied by Recipie fanookian, 102 Woodmobtained via this authorical and health informatical and health informatical eceived.	rmation may d. thorization.  HE NEYS. All ent's office and nont Boulevard ization.
no longer be protected by fe 5. I understand that my attorne 6. I, through my attorney, will  SECTION B: NOTICE TO PRO  The purpose of the release of my rea AUTHORIZATION DOES NOT P. RECIPIENT OR THEIR REPRESE medical records obtained pursuant ta Bates-Numbered copy shall be fur Suite 241, Nashville, TN, 37205, wi  SECTION C: SIGNATURES  I have read the above and authorize Moreover, I acknowledge and hereby	deral privacy regulations and may p y will receive copies of all records r receive a copy of this form after I si  OVIDER AND RECIPIENT  cords is for review by the Recipient ERMIT YOU TO DISCUSS THESE ENTATIVES OUT OF THE PRESE to this authorization by Recipient sha mished to my counsel, Cummings M ithin five days after the records are of the disclosure of the protected med by consent that the released informat s, or AIDS information.	otentially be redisclosed eceived through this aut gn it.  listed above. THIS E MATTERS WITH THORE OF MY ATTORN all be copied by Recipie fanookian, 102 Woodmobtained via this authorical and health informatical and health informatical eceived.	rmation of the contraction of the contraction.

HIPAA AUTHORIZATION FO	R RELEASE OF PROTECTED MED	ICAL/HEALTH INFORMA	ATION
SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATION	īS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: Neurology Clinic & Associates	Recipient's Name: Neurology Clinic & Associate	s	
Provider's Address P.O. Box 414	Address 1: 305 West Main Street		
Brentwood, TN 37024-0414	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	
<ol><li>If I do not sign this form, my unless stated otherwise.</li></ol>	orization and it is strictly voluntary health care and the payment for m	y health care will not be a	

- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

# **SECTION C: SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	3-18-16
	Relationship to Patient (if applicable):

SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS		
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251
Provider's Name:	Recipient's Name:	
Dr. Clark Archer TriStar StoneCrest	Neurology Clinic & Associates	
Provider's Address 200 StoneCrest Boulevard	Address 1: 305 West Main Street	
Smyrna, TN 37167	Address 2:	
	City Lebanon	State TN Zip 37087
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)
Purpose of Disclosure: Compliane	ce with Tenn. Code Ann. § 29-26-12	1
Description of Information to be Us	sed or Disclosed: All PHI in Medica	Record for All Dates
<ul> <li>actions taken prior to receive</li> <li>4. If the requester or receiver is no longer be protected by fe</li> <li>5. I understand that my attorne</li> </ul>	ion at any time in writing, but if I do ing the revocation. s not a health plan or health care pro deral privacy regulations and may p y will receive copies of all records r receive a copy of this form after I si	vider, the released information may otentially be redisclosed. eceived through this authorization.
SECTION B: NOTICE TO PRO	OVIDER AND RECIPIENT	
AUTHORIZATION DOES NOT P RECIPIENT OR THEIR REPRESE medical records obtained pursuant t a Bates-Numbered copy shall be fur		E MATTERS WITH THE NCE OF MY ATTORNEYS. All all be copied by Recipient's office and fanookian, 102 Woodmont Boulevard,
SECTION C: SIGNATURES		
	by consent that the released informat	cal and health information as stated. ion may contain alcohol, drug,
Signature of Patient / Rlan Member	NO	Date: 3-18-16
Print Name of Guardian / Represent	ative (if applicable):	Relationship to Patient (if applicable):

SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATIO	NS
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name: Dr. Clark Archer	Recipient's Name: Neurology Clinic & Associates		
Provider's Address 2910 South Church Street Suite B	Address 1: 305 West Main Street Address 2:		
Murfreesboro, TN 37127			
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	ne following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Complian	ce with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be U	sed or Disclosed: All PHI in Medica	l Record for All Dates	

#### I understand that:

- 1. I may refuse to sign this authorization and it is strictly voluntary.
- 2. If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

# SECTION B: NOTICE TO PROVIDER AND RECIPIENT

The purpose of the release of my records is for review by the Recipient listed above. THIS AUTHORIZATION DOES NOT PERMIT YOU TO DISCUSS THESE MATTERS WITH THE RECIPIENT OR THEIR REPRESENTATIVES OUT OF THE PRESENCE OF MY ATTORNEYS. All medical records obtained pursuant to this authorization by Recipient shall be copied by Recipient's office and a Bates-Numbered copy shall be furnished to my counsel, Cummings Manookian, 102 Woodmont Boulevard, Suite 241, Nashville, TN, 37205, within five days after the records are obtained via this authorization.

# **SECTION C: SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FO	OR RELEASE OF PROTECTED MED	DICAL/HEALTH INFORM.	ATION
SECTION A: THIS SECTION	MUST BE COMPLETED FOR A	LL AUTHORIZATION	NS SP
Patient Name: JOHN RUFFINO	Date of Birth: Social Security No: XXX-XX-7251		
Provider's Name: StoneCrest Medical Center	Recipient's Name: Neurology Clinic & Associates		
Provider's Address 200 StoneCrest Bouelvard	Address 1: 305 West Main Street		
Smyrna, TN 37167	Address 2:		
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	ce with Tenn. Code Ann. § 29-26-12	21	
Description of Information to be Us	sed or Disclosed: All PHI in Medica	Record for All Dates	
<ol><li>If I do not sign this form, my unless stated otherwise.</li></ol>	horization and it is strictly voluntary y health care and the payment for m tion at any time in writing, but if I do	y health care will not be a	

- 4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may potentially be redisclosed.
- 5. I understand that my attorney will receive copies of all records received through this authorization.
- 6. I, through my attorney, will receive a copy of this form after I sign it.

#### NOTICE TO PROVIDER AND RECIPIENT **SECTION B:**

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#### SECTION C: **SIGNATURES**

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):

HIPAA AUTHORIZATION FO	OR RELEASE OF PROTECTED MED	ICAL/HEALTH INFORMA	ATION
SECTION A: THIS SECTION MUST BE COMPLETED FOR ALL AUTHORIZATIONS			
Patient Name: JOHN RUFFINO	Date of Birth: 06-12-1959	Social Security No: XXX-XX-7251	
Provider's Name:	Recipient's Name:		
StoneCrest Medical Center c/o CT Corporation System	Neurology Clinic & Associates		
Provider's Address 800 South Gay Street, #2021	Address 1: 305 West Main Street Address 2:		
Knoxville, TN 37929-9710			
	City Lebanon	State TN	Zip 37087
This authorization will expire on the Date:	e following (fill in the Date or the E Event: Filing of Lawsuit	vent but not both)	
Purpose of Disclosure: Compliance	e with Tenn. Code Ann. § 29-26-12		
Description of Information to be Us	ed or Disclosed: All PHI in Medica	Record for All Dates	
	norization and it is strictly voluntary		CC

- If I do not sign this form, my health care and the payment for my health care will not be affected unless stated otherwise.
- 3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
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# SECTION C: SIGNATURES

Signature of Patient / Rlan Member / Guardian / Representative:	Date: 3-18-16
Print Name of Guardian / Representative (if applicable):	Relationship to Patient (if applicable):